



## Coronavirus Disease 2019 (COVID-19)

# Preparing for COVID-19 in Nursing Homes

Updated May 19, 2020

### Related Pages

[Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#)

[Considerations for Memory Care Units in Long-term Care Facilities](#)

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[Responding to Coronavirus \(COVID-19\) in Nursing Homes](#)

[Testing for Coronavirus \(COVID-19\) in Nursing Homes](#)

[Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19](#)

### Summary of Changes to the Guidance:

- **Tiered recommendations to address nursing homes in different phases of COVID-19 response**
- **Added a recommendation to assign an individual to manage the facility's infection control program**
- **Added guidance about new requirements for nursing homes to report to the National Healthcare Safety Network (NHSN)**
- **Added a recommendation to create a plan for testing residents and healthcare personnel for SARS-CoV-2**

## Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).

**Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities** because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.

The Centers for Medicare and Medicaid Services (CMS) recently issued [Nursing Home Reopening Guidance for State and Local Officials](#)   that outlines criteria that could be used to determine when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented. Nursing homes should consider the current situation in their facility and community and refer to that guidance as well as direction from state and local officials when making decisions about relaxing restrictions. When relaxing any restrictions, nursing homes must **remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP** from severe infections, hospitalizations, and death.

This guidance has been updated and reorganized according to **core IPC practices** that should remain in place even as nursing homes resume normal practices, plus **additional strategies** depending on the stages described in the [CMS Reopening Guidance](#)   or at the direction of state and local officials. This guidance is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

These recommendations supplement the CDC's [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#) and are specific for nursing homes, including skilled nursing facilities.

#### **Additional Key Resources:**

- [Considerations for the Public Health Response to COVID-19 in Nursing Homes](#)
- [Interim Testing in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel](#)
- [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#)
- [Webinar Series — COVID-19 Prevention Messages for Long-Term Care Staff](#)
- [Considerations for Memory Care Units in Long-Term Care Facilities](#)
- [Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19](#)

## Core Practices

*These practices should remain in place even as nursing homes resume normal activities.*

### **Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program.**

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the [facility risk assessment](#).
- CDC has created an [online training course](#)  that can be used to orient individuals to this role in nursing homes.

### **Report COVID-19 cases, facility staffing, and supply information to the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility \(LTCF\) COVID-19 Module](#) weekly.**

- CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process

measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:

- Resident impact and facility capacity
  - Staff and personnel impact
  - Supplies and personal protective equipment
  - Ventilator capacity and supplies
- Weekly data submission to NHSN will meet the [CMS COVID-19 reporting requirements](#).  

### **Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves.**

- Provide information about [COVID-19](#) (including information about signs and symptoms) and strategies for [managing stress and anxiety](#).
- Regularly review CDC's [Infection Control Guidance for Healthcare Professionals about COVID-19](#) for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Including consultants is important, since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of COVID-19.
  - Reinforce sick leave policies, and **remind HCP not to report to work when ill**.
  - Reinforce adherence to standard IPC measures including [hand hygiene](#) and [selection and correct use of personal protective equipment \(PPE\)](#). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
    - CDC has created [training modules for front-line staff](#) that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
  - Educate HCP about any new policies or procedures.
- Educate residents and families on topics including information about COVID-19, actions the facility is taking to protect them and/or their loved ones, any visitor restrictions that are in place, and actions residents and families should take to protect themselves in the facility, emphasizing the importance of hand hygiene and source control.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, [including if cases of COVID-19 are identified among residents or HCP](#).

### **Implement Source Control Measures.**

- HCP should wear a facemask at all times while they are in the facility.
  - When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. [Guidance on extended use and reuse of facemasks](#) is available. **Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required.**
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2.
- Visitors, if permitted into the facility, should wear a cloth face covering while in the facility.

### **Have a Plan for Visitor Restrictions.**

- Send [letters or emails](#)  to families reminding them not to visit when ill or if they have a [known exposure](#) to

someone with COVID-19.

- Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident
- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
  - Screen visitors for fever ( $T \geq 100.0^\circ\text{F}$ ), [symptoms consistent with COVID-19](#), or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- Have a plan for when the facility will implement additional restrictions, ranging from limiting the number of visitors and allowing visitation only during select hours or in select locations to restricting all visitors, except for compassionate care reasons (see below).

### Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2.

- Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as [viral testing](#) or test) among residents and HCP in nursing homes.
- The [plan](#)   should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
  - [Triggers](#) for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance)
  - Access to tests capable of detecting the virus (e.g., polymerase chain reaction) and an arrangement with laboratories to process tests
    - Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.
  - Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
  - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until [symptom-based criteria](#) are met for a symptomatic resident who refuses testing)
- Additional information about testing of residents and HCP is available:
  - [CDC Strategy for COVID-19 Testing Nursing Homes](#).
  - [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#)

### Evaluate and Manage Healthcare Personnel.

- Implement [sick leave policies](#) that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- As part of routine practice, ask HCP (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever ( $T \geq 100.0^\circ\text{F}$ ) or [symptoms consistent with COVID-19](#) while at work they should inform their supervisor and leave the workplace. Have a [plan](#) for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers).

- HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.
  - **Actively take their temperature\*** and document absence of [symptoms consistent with COVID-19](#). If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
  - \*Fever is either measured temperature >100.0°F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations.
  - HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
  - CDC has created guidance to assist facilities with [mitigating staffing shortages](#).
  - For guidance on when HCP with suspected or confirmed COVID-19 may return to work, refer to [Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 \(Interim Guidance\)](#)

### **Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices.**

- Hand Hygiene Supplies:
  - Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Make tissues and trash cans available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Perform and maintain an inventory of PPE in the facility.
    - Identify [health department](#) or [healthcare coalition](#)  contacts for getting assistance during PPE shortages. The Supplies and Personal Protective Equipment pathway in the [NHSN LTCF COVID-19 Module](#) can be used to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of PPE conservation strategies).
    - Monitor daily PPE use to identify when supplies will run low; use the [PPE burn rate calculator](#) or other tools.
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
  - Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
  - Implement [strategies to optimize current PPE supply](#) ***even before shortages occur***, including bundling resident care and treatment activities to minimize entries into resident rooms. Additional strategies might include:
    - [Extended use](#) of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).

- Care must be taken to **avoid touching the respirator, facemask, or eye protection**. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others.
- **Prioritizing gowns** for activities where splashes and sprays are anticipated (including aerosol-generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
  - **If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., *Clostridioides difficile*)**
- Implement a process for decontamination and reuse of PPE such as **face shields and goggles**.
- Facilities should continue to assess PPE supply and current situation to determine when a return to standard practices can be considered.
- Implement a **respiratory protection program** that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- Environmental Cleaning and Disinfection:
  - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
  - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
    - Use an EPA-registered disinfectant from [List N](#)  on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use.

### Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19.

- Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
  - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
  - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. **Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.**
- Have a **plan** for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the [Considerations for the Public Health Response to COVID-19 in Nursing Homes](#)

### Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e.,

goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected.

## Evaluate and Manage Residents with Symptoms of COVID-19.

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever ( $T \geq 100.0^\circ\text{F}$ ) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures  $>99.0^\circ\text{F}$  might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or  $\geq 3$  residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
  - Contact information for the healthcare-associated infections program in each state health department is available here: <https://www.cdc.gov/hai/state-based/index.html>
  - Refer to CDC [resources](#)  for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with COVID-19 is described in the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\)](#). CDC has also developed guidance on [Evaluating and Reporting Persons Under Investigation \(PUI\)](#).
- **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community**, follow the [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#). **This guidance should be implemented immediately once COVID-19 is suspected**
  - Residents with suspected COVID-19 should be prioritized for testing.
  - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
    - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
    - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
  - Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.**
  - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
    - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
  - If a resident requires a higher level of care or the facility cannot fully implement all recommended infection

control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**

- While awaiting transfer, residents should be separated from others (e.g., in a private room with the door closed) and should wear a cloth face covering or facemask (if tolerated) when others are in the room and during transport.
- [All recommended PPE](#) should be used by healthcare personnel when coming in contact with the resident.
- Because of the higher risk of unrecognized infection among residents, universal use of [all recommended PPE](#) for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.
- For decisions on removing residents who have had COVID-19 from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](#)

## Additional Strategies Depending on the Facility's Reopening Status

*These strategies will depend on the stages described in the CMS Reopening Guidance or the direction of state and local officials.*

### Implement Social Distancing Measures

- Implement aggressive social distancing measures (remaining at least 6 feet apart from others):
  - Cancel communal dining and group activities, such as internal and external activities.
  - Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
  - Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.
- Considerations when restrictions are being relaxed include:
  - Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.
  - Allowing for safe, socially distanced outdoor excursions for residents without COVID-19, including those who have fully recovered. Planning for such excursions should address:
    - Use of cloth face covering for residents and facemask by staff (for source control) while they are outside
    - Potential need for additional PPE by staff accompanying residents
    - Rotating schedule to ensure all residents will have an opportunity if desired, but that does not fully disrupt other resident care activities by staff
    - Defining times for outdoor activities so families could plan around the opportunity to see their loved ones

### Implement Visitor Restrictions

- Restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
  - Send [letters or emails](#)  to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
  - Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.

- Post signs at the entrances to the facility advising that no visitors may enter the facility.
- Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or [symptoms consistent with COVID-19](#). Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
- Considerations for visitation when restrictions are being relaxed include:
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

### Healthcare Personnel Monitoring and Restrictions:

- Restrict non-essential healthcare personnel, such as those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers from entering the building.
  - Consider implementing telehealth to offer remote access to care activities.

## Definitions:

- **Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control:** Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Cloth face covering:** Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer. Guidance on design, use, and maintenance of cloth face coverings is [available](#).
- **Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

## Additional Resources

[Recorded webinar, Preparing Nursing Homes and Assisted Living Facilities for COVID-19](#)

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[Long-term Care Facility Letter !\[\]\(d219eb33a83c47f5c6c63c27bbe267cb\_img.jpg\) \[1 page\] to Residents, Families, Friends and Volunteers](#)

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[Nursing Home and Long-Term Care Facility Checklist](#)

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[Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings](#)

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[Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities](#)

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[CMS Emergency Preparedness & Response Operations !\[\]\(9479d69b60a82161c6862eaa53eb4db3\_img.jpg\)](#)

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